Kentucky
Epidemiologic Notes & Reports

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR PUBLIC HEALTH
DIVISION OF EPIDEMIOLOGY

Volume 32 Number 7 July 1997

Disease Surveillance Regulation (902 KAR 2:020) Summary

On June 16, 1997, the first major revision in several years to Kentucky's reportable disease administrative regulation (now called Disease Surveillance regulation) went into effect. The Division of Epidemiology has recognized for some time the need to:

- eliminate those diseases which are no longer of public health importance from the list of required reporting;
- better define the roles of the reporting providers, the local health departments, and the Division of Epidemiology in surveillance; and
- change the approach for some diseases from routine reporting by physicians and hospitals, to sentinel surveillance or to surveillance conducted exclusively through clinical laboratories.

Kentucky Administrative Regulation 902 KAR 2:020, as amended effective June 16, accomplishes all of these goals.

Other noteworthy features of the administrative regulation are:

1 Reportable diseases are divided into those requiring urgent notification (within 24 hours), those requiring priority notification (within one business day), and those requiring routine notification (within five business days). Responsibility for investigating occurrences of diseases in the first group resides at the state level. The Communicable Disease Branch in Frankfort will soon be equipped with an answering machine, which will be checked daily on weekends and holidays, to respond to these reports. The regulation provides a mechanism for rapid reporting which does not require nor allow confidential medical information to be left on tape. Responsibility for investigating diseases in the second group resides with the local health department. The Communicable Disease Branch will render assistance on request. Reports of diseases in the third group will be tabulated and analyzed only -- unless the pattern of occurrence calls for a special investigation.

2 The giving of rabies post-exposure prophylaxis (rabies shots) to humans is now a reportable event. This surveillance system will be managed by Dr. Mike Auslander, state public health veterinarian.

3 A mechanism is set up for sentinel surveillance of resistant infections in hospitals. It is intended that hospitals volunteer for this project -- which will be the responsibility of a nurse consultant in the Surveillance and Investigations Branch.

4 The mechanism for AIDS/HIV reporting has been further clarified, and the national HIV and AIDS reporting forms have been adopted as regulation incorporated by reference. The report form for other diseases is provided for the convenience of those reporting, but is not required by regulation. (See the Insert in this issue.)

5 The existing reporting requirement for lead poisoning has been retained, until the Division of Maternal and Child Health adopts its own regulation to further outline the requirements for lead surveillance.

6 In response to comments by several interested parties, the three-month reporting requirement for three occupational lung diseases has been retained. Arrangements are pending with the University of Kentucky Department of Preventive Medicine and Environmental Health to assume responsibility for surveillance of these conditions on behalf of the Division of Epidemiology.

7 By an extremely fortunate coincidence in timing, the new set of disease surveillance case definitions arrived from CDC in early May, and the Legislative Research Commission was kind enough to allow us a last-minute amendment to incorporate these by reference instead of the 1990 version. Copies of *Case Definitions for Infectious Conditions Under Public Health Surveillance* are available from the Surveillance and Investigations Branch, or on the Internet if you have the appropriate software to read them.

8 At the request of the infection control nurses, we have prepared a Diagrammatic Guide for Disease Reporting, to accompany the new reporting form. Single copies of these were mailed to local health departments and infection control nurses in June. An additional supply is available from the Surveillance and Investigations Branch.

We welcome any questions regarding the new regulation. Please call Dr. Mike Auslander, state public health veterinarian and chief of the S&I Branch at (502) 564-3418, Pat Beeler, reportable disease registrar, at the same number, or Dr. Clarkson Palmer, Communicable Disease Branch Manager and managing supervisor of the Division of Epidemiology, at (502) 564-3261 or (502) 564-7243.

Rabies Postexposure Prophylaxis Survey, Kentucky, 1994

The following article appeared in *Emerging Infectious Diseases,* Volume 33, Number 2, April-June 1997

A survey of rabies postexposure prophylaxis administered by local health departments for a 1-year period showed that very few patients received treatment as a result of exposure to a confirmed rabid animal. Most prophylaxis was administered for contact with domestic animals in situations where existing recommendations for quarantine or laboratory testing of the animal were not followed. Because rabies in domestic animals in Kentucky is uncommon, these findings suggest that had the existing recommendations been followed, the prophylaxis would have been unnecessary in most cases.

Rabies postexposure prophylaxis (PEP) is expensive, not totally free of risk, and overused (1). A national public health objective for the year 2000 is to reduce the number of prophylaxis treatments by 50% (2). In Kentucky, where PEP is administered in public and private settings, there are no baseline data on PEP use.

A survey of local health departments was used to determine the nature of each patient's exposure to rabies. The number of PEP treatments administered by all providers in Kentucky was estimated from local health department information on rabies biologics purchases and use.

SURVEY AND SALES SUMMARY

In May 1995, the 1994 invoices of the Kentucky Department for Health Services, (now Department for Public Health) Vaccine Depot, were reviewed to determine which local health departments received 1.0 ml doses of human diploid cell vaccine for PEP. (Local health departments used 1.0 ml human diploid cell vaccine for PEP only, and 0.1 ml human diploid cell vaccine intradermally for all rabies preexposure prophylaxis). Data from two large health departments that acquired their vaccine directly from the manufacturer rather than from the Vaccine Depot were included in the survey. In June 1995, local health departments that had administered at least one PEP during 1994 were asked to review the records of patients receiving PEP. Information (patient's age and sex, the number of doses of human diploid cell vaccine, whether human rabies immune globulin was administered, exposure information, and method of payment for the treatment) collected on each patient was recorded on a standardized form by the same telephone surveyor during a followup telephone call. All data were entered into an Epi Info Version 5.0 record file and analyzed in either the Analysis or Statcalc Programs for summary statistics and/or odds ratios, confidence intervals, Fisher's exact test, or Chi-square at the .05 significance level (3).

A sales record summary for human diploid cell vaccine sold to all providers in Kentucky was obtained from the only manufacturer of human rabies vaccine recording any sales in Kentucky that year (Connaught Laboratories, Inc., Swiftwater, PA). The number of PEPs administered in the state by all providers was estimated by comparing local health department purchases and use with the total number of human diploid cell vaccine 1.0 ml doses sold to other providers with Kentucky addresses.

PEP ADMINISTRATION PROFILE

Vaccine Depot records indicated that 28 health departments treated a total of 97 patients. The number of PEP regimens administered per health department ranged from 1 to 23 with a median of 1 PEP for the year. Fifty-two (53.6%) of the patients were male (Table 1); the median age was 28 years (range 2 to 71); 34 (35.1%) patients were younger than 18 years of age; 59 (60.8%) were older than 18 years of age; and for 4 (4.1%), age was unknown. No significant differences were observed in the type of animal exposure by sex or age. Seven patients (7.2%) had previously received PEP and were treated with two to three doses of human diploid cell vaccine and no human rabies immune globulin.

Urban health departments (in the three metropolitan statistical areas of the state) were more likely to administer PEP than rural health departments (odds ratio = 1.54, confidence interval = 1.01, 2.33) (4). Patients did not significantly differ in age, sex, or type of exposure between urban and rural health departments.

For 25 (25.8%) of the patients, local health department funds covered the expense of PEP treatments; no payment was received from private insurance, Medicaid, Medicare, or the patient. There were no significant differences in payment characteristics between urban and rural health department patients.

Table 1. Characteristics of local health department patients receiving rabies postexposure prophylaxis.

SEX	
Male	52
Female	43
Unspecified	2
AGE[a]	
Youth (2 - 10)	19
Adolescent (11 - 17)	15
Adult (18-71)	59
Unspecified	4
Health department location[b]	
Urban	48
Rural	49
Previously immunized	6
Animal exposure	
Wild	15
Domestic (50 dogs, 29 cats, 1 horse)	80
Unspecified	2
Type of exposure	
Bite or contact with saliva	72
No contact with saliva	17
Unspecified	8
Treatment payer	
Private insurance	39
Medicaid	7
Medicare	3
Patient	14
Other (employer, worker's compensation)	3
Unspecified	6
No reimbursement	25

(N=97)
[a] mean = 28 yrs.
[b] Health departments in urban areas, as defined by the 1990 census of population for Kentucky. Metropolitan statistical areas were more likely to administer PEP than rural departments. (p=.033)

Bite exposures were responsible for 71 (73.2%) of the 97 PEP treatments, 18 (18.6%) exposures were scratches, licks, or "other," and 8 (8.2%) exposure types were not recorded. Domestic animals accounted for 80 (82.5%) of the exposures treated.

TYPE OF ANIMAL EXPOSURE

Sixty-four (77.1%) of 83 animals involved in these incidents were not available for observation or testing. For wild animals, testing was performed in 3 (20%) of 15 incidents. Testing or observation occurred in only 16 (20.0%) of 80 domestic animal exposures.

Stray domestic animals accounted for 26 (26.8%) of all exposures. Another 19 (19.6%) of the incidents involved owned dogs that were unavailable for testing or observation. Unavailability for testing was due to severe brain damage caused by clubbing or gunshot by irate owners, death and disposal of the animal without testing, or the animal's escape. For 36 (37%) incidents, the reason for not testing or observing the animal was not specified.

Thirteen (13.4%) of the patients were exposed to an animal that was tested and found to be positive for rabies, and two of these patients had bite exposures. T he remaining exposures to these rabies-positive animals were either low-risk exposures or not true exposures (Table 2).

Table 2. Patients receiving postexposure prophylaxis for exposure to a confirmed rabid animal inKentucky, 1994

Species	Type of exposure	Previous history of prophylaxi
Bat	Bite	No
Cat(a)	Mucus & Saliva	Yes(b)
Cat(a)	Mucus & Saliva	No
Cat(a)	Cleaned exam table	No
Cat(a)	Cleaned exam instruments	No
Dog(c)	Bite	Yes
Dog(c)	Touch	Yes
Dog(c)	Touch	Yes
Dog(c)	Touch	Yes
Dog(c)	Touch	No
Dog(c)	Touch	No
Horse	Sutured wound	Yes(b)
Skunk	Touch	No

(a) Same cat
(b) Veterinarian with history of preexposure prophylaxis
(c) Same dog

TOTAL ESTIMATE OF STATE RABIES POSTEXPOSURE PROPHYLAXIS

Kentucky sales in 1994 for human diploid cell vaccine 1.0 ml to nonmilitary providers and distributors totaled 1,603 doses. The health departments ordered 700 of these doses, of which 445 were used for PEP in that same year. The other doses remained as inventory. Assuming that other users administered human diploid cell vaccine 1.0 ml in a similar proportion (445/700=.64), the private sector administered 578 doses (903 x .64) of human diploid cell vaccine 1.0 ml. Comparing actual local health department use of human diploid cell vaccine 1.0 ml and estimated use by others, local health departments administered 43.5% (445/([445+578]) of the human diploid cell vaccine 1.0 ml used in the state in 1994. Therefore, the estimated total number of PEP patients in the

state is 223 (97/.435) for 1994.

Exact total costs for PEP administration cannot be calculated since most treatments were made by private providers. The actual cost of biologics to local health department patients in 1994 was $68,850. Estimated costs of biologics used by private providers (based on estimates of hospital pharmacy costs in Connecticut in 1994) would be $180,180 for a typical patient (126 patients x $1,430) (5). Estimated total costs of biologics is $249,030. Unknown costs include medical and hospital care, local health department investigation of the incident, state health department consultations, and loss of work income by the patient.

STUDY LIMITATIONS

Because records at the local health departments were not always complete or as detailed as desired, certain variables could not be analyzed for all 97 cases; information about why the suspect animal was not tested or observed for rabies was absent from more than 10% of the cases. Since no detailed information was obtained from the private sector, we assumed that the number of doses used per patient, inventory, waste, spoilage, and other factors influencing PEP use in the private sector were similar to those in the public sector. Kentucky residents receiving PEP in another state and out-of-state residents receiving PEP in Kentucky would not be specifically accounted for in our estimate.

The difference in urban versus rural PEP administration could be due to differences in the number of animals or bite incidents; however, the number of animals or animal bites statewide is not known. An investigation of prescribing practices of full-time physicians at large, urban health departments and part-time or contract physicians at small, rural health departments might determine if these practices contributed to treatment disparity.

GUIDELINES AND NONCOMPLIANCE

Guidelines for determining exposures that warrant PEP exist (6,7). Ideally, any animal involved in a human exposure should be confined and observed or tested for rabies, whichever is appropriate. It is understandable that most of the wild animals might have escaped and not be available for testing. However, the large proportion of domestic animals unavailable for testing indicates inappropriate handling of the incident or a breach of existing laws (5-7).

Six people received PEP due to exposure to a single dog with laboratory-confirmed rabies. This particular incident illustrates how "anything that can go wrong will go wrong." First, the dog had been vaccinated by the owner. It is illegal for individual owners to vaccinate their own dogs in Kentucky (8). Second, the vaccine may have failed for any number of reasons, including vaccine failure, improper handling/administration of the vaccine, or failure to vaccinate. Third, only one of these patients was bitten; the other five reported only touching the dog and probably were not exposed. Fourth, none of these patients had insurance or was able to pay for treatment; thus, the local health departments spent several thousand dollars in unbudgeted expenses. Furthermore, four of these patients had received PEP before.

Noncompliance with existing public health recommendations and laws contributes to the number of rabies exposure incidents in Kentucky. PEP administration in Kentucky could be reduced if existing recommendations and laws were adhered to by the public and health care providers. Accurate and complete record keeping is essential for assessing the use of PEP. Additionally, making PEP a notifiable (reportable) condition would allow public health agencies to assess PEP administration in the private sector.

This article was contributed by: Michael Auslander, DVM, MSPH, State Public Health Veterinarian, and Colleen Kaelin, Kentucky Department for Public Health.

Emergency Phone Numnbers – Evening or Weekend

For any emergency phone call after the normal working hours of 8:00 AM - 4:30 PM - Monday - Friday you may contact a staff member of the Division of Epidemiology as shown below:

Peggy Wright, RN	**(502) 839-5422**
Michael Auslander, DVM, MSPH	**(502) 493-8177**
Clarkson Palmer, MD, MPH	**(502) 223-4607**

KENTUCKY EPIDEMIOLOGIC NOTES & REPORTS
Printed With State Funds
by the
COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR PUBLIC HEALTH
275 EAST MAIN STREET
FRANKFORT, KENTUCKY 40621

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and
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Division of Epidemiology
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In This Issue . . .

Arrival . . . .

New Reportable Disease Reporting Form (EPID-200) - See Insert

The insert in this issue of *Kentucky Epidemiological Notes and Reports* is a copy of the new Reportable Disease Reporting form. The new reportable diseases and conditions are on this form as are the new reporting time frames. Please use this insert to make copies for reporting diseases and conditions on the list or contact your local health department or the Division of Epidemiology for these new forms.

The article on Page 1 of this issue summarizes the recently promulgated administrative regulation, 902 KAR 2:020, Disease Surveillance. A copy of this new administrative regulation, which became effective on June 16, 1997, can be found in the July issue of the Legislative Research Commissions publication, *The Administrative Register,* or you may contact the Surveillance and Investigation Branch of the Division of Epidemiology for a copy of 902 KAR 2:020. The phone number for the Surveillance and Investigation Branch is (502) 564-3418.

In This Issue . . .

This is a copy of the announcement which will appear in the July issue of *Kentucky Epidemiologic Notes and Reports* and a copy of the new Reportable Disease Reporting Form (EPID-200, Revised 6/97). You may make copies of the insert and begin using it for reporting after June 16, 1997. Please maintain an original form for future copying.

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EPID 200 (REV 6/97)

KENTUCKY REPORTABLE DISEASE FORM

Cabinet for Health Services
Department for Public Health
275 East Main Street
Frankfort, KY 40621
(502) 564-3418

Please complete legibly the following information for each occurrence of a reportable disease (listed below).

Disease name_____

Patient Name_____ **DOB**_____/_____/_____ **Age**_____ **Circle one in each box:**
Last First MI

Address_____
Street City Zip

Sex	Race	Ethnicity
M F U	B WA\PI I\AN O	H NH

County _____ **Home Phone #** (_____) _____ - _____

Date of onset _____ / _____ / ____ **Date of diagnosis** _____ / _____ / _____

Diagnosed by _____ **Phone #** (_____) _____ - _____

List symptoms _____ **Highest temperature** _____ **Days of diarrhea** _____

Associated with daycare? Y _____ **N** _____ **Name of daycare** _____

Food handler? Y____ **N**____ **Where?** _____ **Associated with outbreak? Y** _____ **N** _____

Hospital adm. date _____ / _____ / _____ **Discharge date** _____ / _____ / _____ **Name of hospital** _____

Comments _____

LABORATORY INFORMATION			
DATE	**TEST**	**SPECIMEN SOURCE**	**RESULT**

ADDITIONAL INFORMATION FOR SEXUALLY TRANSMITTED DISEASES ONLY

Disease stage and type _____ **Date reported** _____/_____/_____ **Date treated** _____/_____/_____

Type and amount of treatment _____ **If syphilis, was previous treatment given for this infection? Y**____ **N**____

If yes, approximate date _____/_____/_____ **and place** _____

Method of case detection:
Prenatal _____ **Community & Screening** ____ **Delivery** _____ **Instit. Screening** _____ **Reactor** ____
Provider Report ____ **Volunteer** _____

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902 KAR 2:020 requires health professionals to report the following diseases to the local health departments serving the jurisdiction in which the patient resides or Department for Public Health. (Copies of 902 KAR 2:020 available upon request).

❋Please note: Complete additional information for selected diseases.

REPORT WITHIN 24 HOURS

- Anthrax
- Botulism
- Cholera
- Diphtheria
- Enceph. California group
- Enceph. Eastern equine
- Enceph. St. Louis
- Enceph. Western
- Group A streptococcal infection, invasive
- Hansen's disease
- Hantavirus infection
- ❋*Haemophilus influenzae* invasive disease
- Measles
- ❋Meningococcal infection
- Pertussis
- Plague
- Poliomyelitis
- Psittacosis
- Rabies, human
- Rubella
- Rubella syndrome, congenital
- Syphilis, primary, secondary, early latent or congenital
- Tetanus
- Toxic shock syndrome
- Typhoid fever
- Yellow fever

REPORT WITHIN ONE (1) BUSINESS DAY

- *E.coli* O157:H7
- Ehrlichiosis
- ❋Hepatitis A
- Lyme disease
- Malaria
- Mumps
- ❋Rocky Mountain Spotted Fever
- Shigellosis
- Tuberculosis
- Animal conditions known to be communicable to man

REPORT WITHIN FIVE (5) BUSINESS DAYS

- †AIDS
- Brucellosis
- Chancroid
- Chlamydia trachomatis infection
- Gonorrhea
- ❋Hepatitis B, acute
- ❋Hepatitis B, in a pregnant woman or a child born in or after 1992
- ❋Hepatitis C, acute
- Histoplasmosis
- †HIV infections
- Lead poisoning
- Legionellosis
- ❋Listeriosis
- ❋Rabies post-exposure prophylaxis
- Syphilis, other than primary, secondary, early latent or congenital
- Tularemia

† All cases of HIV infections/AIDS are reportable for a separate surveillance system in accordance with KRS 211.180(1)b. To obtain report forms contact the HIV/AIDS Branch at (502) 564-6539. DO NOT REPORT ON THIS FORM.

REPORT ON A WEEKLY BASIS

- Campylobacter isolates
- Cryptosporidium oocysts
- Influenza virus isolates
- Salmonella isolates

NOTE: Animal bites shall be reported to local health departments within twelve (12) hours in accordance with KRS 258.065

Person completing form _____ **Date completed** _____/_____/_____ **Phone #** (_____) _____ - _____

Agency _____

❖ADDITIONAL INFORMATION FOR BACTERIAL MENINGITIS AND BACTEREMIA CASES

TYPE OF INFECTION CAUSED BY ORGANISM:
(Check all that apply)

Primary					
Bacteremia ___	Cellulitis ___	Septic arthritis ___
Meningitis ___	Epiglottitis ___	Conjunctivitis ___
Otitis media ___	Peritonitis ___	Pericarditis ___
Pneumonia ___	Other (Specify)_____	

BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:*
(Check one)

Neisseria meningitidis ____ *Streptococcus pneumoniae** (pneumococcus)____
Haemophilus influenzae ____ Other Bacterial Species* ____
Group B streptococcus ____ (Specify: include mycobacteria fungi)
Listeria monocytogenes ____ _____
* (Report ONLY CSF isolates for Pneumococcus or Other Bacterial Species)

SPECIMEN FROM WHICH ORGANISM ISOLATED: (Check all that apply)

Blood____ CSF___ Pleural Fluid ___ Peritoneal Fluid ___ Pericardial Fluid ___ Joint ___ Placenta ___ Other Normally Sterile Site : (Specify)
_____

Number of contacts prophylaxed_____

HAEMOPHILUS INFLUENZAE:
Did patient receive *Haemophilus b* vaccine? Y___ N___ U___

How many doses did patient receive? _____

What was serotype? Type b____ Not tested or unknown ____

Other ____ (Specify) _____

NEISSERIA MENINGITIDIS
What was the serogroup? Group A ____ Group B ____ Group C ____

Group Y____ Group W135 ____ Not groupable _____ Unknown ____

Not Typable ____ Other ____ (Specify) _____

If *N. meningitidis* was isolated from blood or CSF, was it resistant to:

Sulfa - Y____ N____ U____ Rifampin - Y____ N____ U ____

If *H. influenzae* was isolated from blood or CSF, was it resistant to:
Ampicillin - Y____ N ____ U____ Chloramphenicol - Y____ N ____ U

❖ADDITIONAL INFORMATION FOR ACUTE VIRAL HEPATITIS

Pregnant ? Yes_____ No _____ Jaundice? Yes_____ No _____ List Other Symptoms: _____

Laboratory Results

a. Serum aminotransferase levels

	Patient	Reference	Normal
AST (SGOT)	_____	_____ U/L	<30-50 U/L
or			
ALT (SGPT)	_____	_____ U/L	<30-50 U/L

b. Hepatitis markers

HBsAg	Results _____
IgM anti-HBc	Results _____
IgM anti HAV	Results _____
Anti HBc	Results _____
Others (Specify)	_____

❖ADDITIONAL INFORMATION FOR ROCKY MOUNTAIN SPOTTED FEVER

Tick bite or attachment within 14 days of onset? Y____ N____ U____ Family members with similar illness this year? Y____ N____ U____

Travel outside of county within 14 days of onset? Y____ N____ U____ If yes, where?_____

SEROLOGY (TITERS)	Results	Date	Results	Date
Indirect fluorescent antibody (IFA)	_____	_____	_____	_____
Complement fixation (CF)	_____	_____	_____	_____
Microagglutination (MA)	_____	_____	_____	_____
Proteus OX19	_____	_____	_____	_____
Proteus OX2	_____	_____	_____	_____
Latex agglutination (LA)	_____	_____	_____	_____
Other (Specify)	_____	_____	_____	_____

❖RABIES POSTEXPOSURE PROPHYLAXIS SUPPLEMENTAL INFORMATION

Animal causing exposure (dog, cat, bat, skunk, etc.) _____ Specify type of exposure (bite, lick, other): _____

Animal available for 10 day observation? Y____ N____ Animal killed? Y____ N____ Animal tested? Y____ N____

Test result : Pos.____ Neg.____ If not observed or tested, why not? _____

Did animal exhibit signs of rabies? Y____ N____ If yes, explain _____

Did animal die of natural causes? Y____ N____ If yes, when? _____/_____/_____

If a domestic animal, was it owned? Y____ N____ Was it vaccinated for rabies? Y____ N____ If yes, when? _____/_____/_____

Human diploid cell vaccine (HDCV) - Started _____/_____/_____ Last HDCV _____/_____/_____ Total # doses _____

Was human rabies immune globulin (HRIG) administered? Y____ N____ If yes, when? _____/_____/_____ How much? _____ ml.

Payment source: Private insurance ____ Medicaid ____ Medicare ____ Workers Comp. ____ Out-of-pocket ____ No payment ____